Centre universitaire de santé McGill | McGill University Health Centre

MUHC Reproductive Centre – Self Assessment Form

Patient	*Partner (if applicable)*
PATIENT RVH BLUE CARD NUMBER/IMPRINT	PARTNER RVH BLUE CARD NUMBER/IMPRINT

Please complete this form and prepare a list of questions you might wish to ask the doctor. All information provided will be treated as strictly confidential.

Referring Doctor (if applicable)

Name _____ Telephone _____

Address _____

☐ General Practitioner ☐ Gynecologist ☐ Other Specialist

DEMOGRAPHIC INFORMATION

	Patient	Partner
First Name		
Last Name		
Gender (M/F/Other)		
Date of Birth		
Age		
Occupation		

GENERAL HEALTH

	Patient	Partner
Height		
Weight		
Smoking	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**
If yes, how many cigarettes per week		
Alcohol	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**
If yes, how many drinks per week		

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MEDICAL HISTORY - PATIENT

Medical Conditions
Have you had any illnesses in the past, including any mental health disorders?
If yes, please provide details. ☐ **Yes** ☐ **No**

Are there any diseases or medical problems that run in your family?
(Example: Sickle Cell / Thalassemia Status - negative / trait) If yes, please provide details. ☐ **Yes** ☐ **No**

Past Surgeries
Have you had surgeries in the past? If yes, please list. ☐ **Yes** ☐ **No**

Medication
Are you on any long term medications. If yes, please give names and dosages. ☐ **Yes** ☐ **No**

Allergies
Do you have any allergies? If yes, please give details. ☐ **Yes** ☐ **No**

SECTION FOR FEMALE PATIENTS

Pap Test
Last performed _____ Was it normal? ☐ **Yes** ☐ **No**

Have you ever had an abnormal result? ☐ **Yes** ☐ **No** If yes, give dates _____

PREGNANCY HISTORY

Year	Outcome	Current Partner?
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No

PARTNER HEALTH HISTORY

Medical Conditions
Have you had any illnesses in the past, including any mental health disorders?
If yes, please provide details. ☐ **Yes** ☐ **No**

Are there any diseases or medical problems that run in your family?
(Example: Sickle Cell / Thalassemia Status - negative / trait) If yes, please provide details. ☐ **Yes** ☐ **No**

Past Surgeries
Have you had surgeries in the past? If yes, please list. ☐ **Yes** ☐ **No**

Medication
Are you on any long term medications. If yes, please give names and dosages. ☐ **Yes** ☐ **No**

Allergies
Do you have any allergies? If yes, please give details. ☐ **Yes** ☐ **No**

SECTION FOR FEMALE PARTNERS

Pap Test
Last performed _____ Was it normal? ☐ **Yes** ☐ **No**

Have you ever had an abnormal result? ☐ **Yes** ☐ **No** If yes, give dates _____

PREGNANCY HISTORY

Year	Outcome	Current Partner?
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No

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INFERTILITY HISTORY

As a couple, how many years have you been having sexual intercourse without using contraception? _____Year(s)

☐ **Not Applicable**

Have you had previous infertility investigations? If yes, please provide details.

Patient	☐ **Yes** ☐ **No**	Partner	☐ **Yes** ☐ **No**

TREATMENT HISTORY

Please complete this table if you ever had ovulation induction with or without intrauterine insemination (IUI):

	Treatment 1	**Treatment 2**	**Treatment 3**	**Treatment 4**	**Treatment 5**
Year					
Number of cycles					
IVF Centre					
Clomid (Yes/No)					
Gonadotropins (Yes/No)					
Intrauterine Insemination (Yes/No)					
Partner or Donor Sperm					
Abandoned (Yes/No)					
Pregnancy (Yes/No)					

Have you ever had In-Vitro Fertilization? ☐ **Yes** ☐ **No**

If yes, please complete this table:

	Cycle 1	**Cycle 2**	**Cycle 3**	**Cycle 4**	**Cycle 5**
Year					
Doctor					
IVF Centre					
Gonadotropin Dose					
Number of eggs obtained					
Number of eggs fertilized					
Embryos transferred					
ICSI (Yes/No)					
Partner or Donor Sperm					
Abandoned (Yes/No)					
Pregnancy (Yes/No)					